Vocabulary Task Force
Draft Transcript
May 5, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Vocabulary Task Force. This is an hour and half federal advisory call so there will be opportunity at the end of the call for the public to make comment. Just a reminder, workgroup members, please remember to identify yourselves.

Now let me do a quick roll call: Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Clem McDonald?

Clem McDonald – Regenstrief – Director & Research Scientist
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Stuart Nelson? Marjorie Rallins?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Stan Huff?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Chris Chute? Mark Overhage? Daniel Vreeman?

Daniel Vreeman – Regenstrief Institute – Research Scientist
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Trudel? Don Bechtel could not make it. Patty Greim? Jim Walker? Doug Fridsma? Andy Wiesenthal? Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bob Dolin? Ram Sriram? Ken Gebhart? Lynn Gilbertson? Nancy Orvis? Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I just joined.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great, thank you, Chris. I'll turn it over to Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Hi, thanks everybody. So what we wanted to do on this call today is to go back and review the previous recommendations of the HIT Standards Committee to the National Coordinator for the particular vocabularies that Doug Fridsma has asked us to work on, being problems, labs, and meds. I expect we'll have a somewhat broader discussion than that, but the primary purpose of this call is to review those previous recommendations and then assess what has changed since then and so forth, in terms of their potential applicability for new recommendations to arrive at a singular set of standards for each of the respective purposes.

What I'm going to ask first is, did everybody get the materials that were distributed by Judy—and thank you, Judy, for sending those out. Rather let me ask it this way, is there anyone who does not have the transmittal package from 2009?

Okay what I'm going to request then is, there's a summary chart that is attached at the end of the transmittal letter. There's a chart from the joint working groups and quality and operations, and then following that is a Clinical Operations Workgroup summary from the 20th of August, 2009, that was part of the transmittal letter. I'm going to suggest we start on that and the one that I'd like to start the discussion on is the medication vocabulary. What we had recommended back originally was essentially RxNorm, or the components of RxNorm, for stage one of meaningful use and then for stage two, moving to RxNorm itself. Then also we had in the notes, but which are over in the right hand column, that the use of NDFRT and structured product labeling would need to be to be determined.

What I'd like to ask the group for discussion is, at what point—or what the industry readiness that you all see in terms of readiness to actually move to RxNorm first?

Betsy Humphreys – National Library of Medicine – Deputy Director
Jamie, what page of this table are you on?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay, so I'm on the table that's labeled—so there are, let's see—

M
I think you're on page three.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think it's the first five or six pages of the table are labeled HIT Standards Committee Joint Working Groups on Quality and Operations.

Betsy Humphreys – National Library of Medicine – Deputy Director
Oh, I'm looking under the various medication dispensing and issues here.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So skip past those and then the next table—unfortunately the page is not numbered on the page and I have a printout so I don't have it online to see which page it is. It's probably something like page 12 or 14 of the total document.

Betsy Humphreys – National Library of Medicine – Deputy Director
Okay, I see it now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
It's called Clinical Operations Workgroup Recommendations 20th of August 2009.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes, thank you. I was looking at the wrong spot.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
That's our summary table, and about 40% of the way down that page is a line that says "Medication Vocabulary."

M
I'm having the same trouble still, as Betsy had. The page numbers like three of six, four of six—

W
It's beyond that. It's actually going in the other direction.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Alright, so go past those six pages.

M
In the PDF, it's actually page 10.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Page 10, alright.

W
It's right after page six of six.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
There we go, and it's now displayed on the Web. Actually if the Web could be zoomed up a little more it would probably be more readable. Okay, so we're on the row labeled "Medication Vocabulary." There it is on the Web. So I think the first question might be—or what I was asking rather was the industry readiness to move to RxNorm and what's the feeling of the workgroup, or the task force rather, on that question?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I'd respond a couple of ways. I think our own ability and I think ability of a lot of systems would be technically able, essentially, to substitute RxNorm for codes that we're now using from one of the drug knowledge based vendors. The question that always comes up is, is there somebody who's actually using it in a production environment to validate that there aren't significant omissions in RxNorm. Do you that, Clem? I mean, have we got somebody in production use on—?

Clem McDonald – Regenstrief – Director & Research Scientist
I know two places. I know Regenstrief has made—I think is using it as their primary codes but I don't know the intimate—the real down and dirty details. I know Henry Choi at Partners is using it. The barrier they ran into was that—we haven't sorted through this totally, but the Rx e-prescribing people said you can't use it in the message even though they're using it locally. We've done a fair amount of analysis. It's very complete. So I would argue that it is ready and it would be a help to the industry because of the sort of the confusing way e-prescribing is done now. I think a lot of it is still being sent as text or it's being sent in NDC surrogates, where it's not necessarily the actual product we're sending but it's one that's close enough. Stuart, you might speak better to this point.

Betsy Humphreys – National Library of Medicine – Deputy Director
I think we can get some data behind this. We believe that the coverage now is extremely high and there have been some studies to show it.

M
… production use at this point in time?

Clem McDonald – Regenstrief – Director & Research Scientist
Well the other piece of information that I understand is true but would be worth verifying is at least two of the large knowledge base vendors support it in their system. I believe it's true that First Data and ….

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I guess my question is—I know RxNorm and NDF have been more tightly integrated over the past year or two, but what is the status of mapping of RxNorm codes to useful drug classes, since in a lot of the EMR use cases, certainly decision support, it's ultimately drug classes that tend to be the functional operating key. I know there's been some issues with that for a while.

Clem McDonald – Regenstrief – Director & Research Scientist
Well again, I hate to be the only one talking, but there is considerable progress made but I don't think it's the final, perfect answer. We've recently used it to classify some drugs in some studies we've been doing and it has most of the classes you've recognized in the knowledge bases NDFRT … such as first, second, and third generation cephalosporin.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Is it still true that the drugs are assigned to one and only one class? I mean I know we encountered situations where some preparations of topical corticosteroids were assigned to topical agents as a class. Other preparations of the same darn agent were assigned to corticosteroids and it was almost arbitrary.

Clem McDonald – Regenstrief – Director & Research Scientist
I think there may be still some glitches there but the thing is we're really not comparing—some of the knowledge bases that are available, the commercial ones, really have pretty good classes. They're not all polyhierarchy, however. The challenge really is whether we're really sending out these e-prescribing messages now, and what I understand it's text or NDC. They don't have anything like that either. So I think it's a step forward and currently I think the knowledge bases are what people depend on.

M
Yes, that's the way we would use it, Chris. I mean we would use the RxNorm code as a primary code but we would still subscribe, in our case, to First DataBank for the drug interaction, hierarchies, and other things. The other reason is there's a lot of other information like standard wholesale cost and a whole bunch of other things that we use out on the First DataBank. So using this code creates a new degree of interoperability but we would plan to continue to subscribe to First DataBank for a lot of the other capabilities that actually we think they're probably source right now for that information. Not just the drug hierarchies but also a bunch of wholesale cost and other things like that that are of value to us.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Okay, that's helpful. Thanks.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Remind me of the timeframe if we said yes to this—because in my mind there's really not a question, I don't think, that this is where we want to go. If we said yes, are we obligating people to do this in 2013?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think that is the key question, Stan. Because I think if we say yes, it would obligate the people who want to get incentives in the first year or two to do it in 2013. I don't know how other folks feel about the feasibility of that kind of a transition in what appears to me to be a relatively short timeframe.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
So with the caveat that we're unusual—I mean we can do it in that timeframe but I don't know that I—what we need is someone from Cerner and Epic to say what it would it mean to them.

Clem McDonald – Regenstrief – Director & Research Scientist
Well I think it really depends upon the knowledge base vendors, the success of this because most of the commercial pharmacy systems are using one of them. So if they already have the tables then it should be fairly trivial to ship the messages out with the RxNorm code. The RxNorm code is then, it's part of both the I don't know the exact decimal, like the version 8 point something and the version 10 point something NCPDP standard. Currently I think it's kind of tragic that stuff—there's just a lot junk being sent around in that message standard because there's no kind of chosen code.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
There was an RxNorm pilot—I think Betsy alluded to that. That was a few years ago but there are statistics from that that could be pulled. RxNorm is available code list in the e-prescribing script standard as well as formulary and benefit and the industry is moving toward it. It is correct that the drug knowledge base companies are incorporating this into the use for the e-prescribing function. Obviously, it would not be for the dispensing function but part of it is just the industry movement to become comfortable with this new code set and be clear that the intent and the RxNorm code match since there were stopgap items picked beforehand when there wasn't a code list available for use. So it's getting off that environment and getting comfortable with that.

We did publish guidance for e-prescribing for the use of RxNorm and how to use it in the transaction standards, how do you use it the appropriate way so that effort is underway. There has been a tremendous amount of confusion though in the testing for meaningful use because the regulations cited the different 10 or 12 list of possibles and RxNorm and so there has been a lot of confusion – "Well why can't I send a proprietary code to test?" Yes, you could send a new Rx, new prescription, with a proprietary code that's on one those lists, but what are you testing then? That you can do it? Great, but it's not very interoperable if the receiver doesn't have that code list, that drug database or whatever. So we've added, just recently, additional guidance that says the intent of the industry is to test that RxNorm works as the prescribed medication. This is the intent we recommend that for the meaningful use testing, that you use RxNorm to test.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
I think one of the things to think about with this is, is there a way? I like this discussion around testing and kind of where our intent is. One of the strategies to think about is that if a vocabulary is adopted as a standard, we I think also need to be able to establish certification criteria around those standards. The HITECH Act actually gives the HIT Standards Committee the charge to come up with both standards and certification criteria. Now that certification criteria could involve, say the most commonly prescribed drugs and say that those are the ones that we really think are critical to get our down payment towards interoperability. That would help, I think, for those individuals or those organizations for which there is a proprietary code set. It scales the problem for them a little bit, that they don't have to necessarily try to do everything. But I think then the other piece to that is that suppose there are a thousand drugs that are identified as part of the certification criteria.

I think it becomes important then to be able to have sort of a double strategy, which is one organization to get certified the certification criteria, you need to be able to transmit the ones that are within the most common or the identified subset. But then also that systems that are receiving that information can't break if somebody gets a code set or value or proprietary code that is outside that kind of set. That second category may impede kind of that machine semantic interoperability, but it gives a clear direction as to where we might go. It also, I think, provides kind of a scalable incremental approach. So there may be a way in which standards and certification criteria can be identified that are perhaps slightly nuance that get us toward the policy objective but still makes it possible for organizations to incrementally build towards the goals that we have.

Betsy Humphreys – National Library of Medicine – Deputy Director
I think that what Doug says is right. Our approach is just to set up. I personally think that in terms of a proposal, to go in a proposed rule it would make sense for it to be our RxNorm. I also think that if you wanted to go the subset approach, then it's going to be easy enough for there to be a publicly available service because there already is one, we would just make it slicker. Where if you got an RxNorm code from someone and it wasn't one of the ones that you had goaled on, that you would be able to send a message and find out what it was. I have been rooting around here and I gather that Stanford Hospital does use RxNorm in their productions e-prescribing now.

Clem McDonald – Regenstrief – Director & Research Scientist
To the point about the subset, that's probably a good point because our RxNorm is a big set and many of the things in it aren't actually available anymore so we might propose maybe two levels of subsets; one is the set of things that we're pretty sure are active, and I think that's a defined subset. Then maybe another one based on statistics but I don't know how people think of that.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Could I raise a provocative question and that is, is there utility for considering RxTerms, which deconstructs the sort of overloaded compositional model of RxNorm that has dosage size and drug sort of pre-coordinated, get that information model issues and how we regard terminologies and their use and meaningful use. I would hope that dosage size could be managed at its own entity rather than a forced pre-coordination with a drug agent name, and RxTerms to my understanding actually achieves that.

Clem McDonald – Regenstrief – Director & Research Scientist
When you get them, of course I'm prejudiced so I shouldn't speak. But you get them both; it kind of comes with RxNorm but I think there is probably some tweaking needed.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well the issue, I guess, is whether Chris, you're saying that the fully expressed RxNorm form contains things that are not included in prescription. It was designed to include things that would be in a prescription.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Well, I think it's true. It's pragmatic and it's usable but I'm just thinking of this from an information representation perspective. If we're interested in any way in secondary use and other kinds of things why conflate data elements into a pre-coordinated term when I think a lot of information in theory suggests that, to the extent that you can keep data and rolls and semantic types clean. Whereas with RxNorm you're really—you've got a dose size, you've got a physical quantity, you've got a measure, you've got a drug, you've got all kinds of stuff going on in RxNorm whereas RxTerms, which is as Clem knows perhaps better than anybody, in a sense the vocabulary parent of RxNorm. I mean they're joined at the hip. I understand that. It's not as though we're changing horses; we're just keeping clear what's the horse and what's the saddle—may be a more attractive way to go in terms of a national vocabulary standard.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, I think the issue is, the way I have viewed it, and I can stand corrected, is that the RxTerms approach is, I think, very useful for data entry and also for display of certain things. But if I am sending a

specific prescription and I want it filled, my understanding was that I would need the elements that are in RxNorm in order to get what I was asking for.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Well, you'd need the additional data of what dose you want but essentially it requires the specification of a … whereas we all know that in dispensing you can sometimes give two 50 mg tablets instead of 100 mg tablets, it's functionally the same. Prewiring that pill size into RxNorm when, in fact, it may not have any bearing on dispensing and it may not have any bearing on inventory and other issues, seems to be overloading information that, yes you need the amount of the drug that you want prescribe in the prescription. But I don't see why it should be bound to the RxNorm elements. In fact, if you want 100 mg tabs and you want to prescribe two tabs, you're actually making the dose very confusing because then it's two tabs of something that's bound within the name.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I agree with your intent, Chris, but there's actually use cases when you want to do exactly that. So I think you want to allow the other part so the use case I would bring forward is in our anticoagulation clinic; we're prescribing Coumadin and they're different sizes. What they want to do is they want to actually prescribe the pill size because they know they're going to adjust and they want to adjust by 2.5 mg. So they want to give them pill sizes so that they can adjust based on a known pill size and not have to have them come back and get a new pill size because they adjusted their dose.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I'm not saying pill size shouldn't be part of the prescription, Stan.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
No, I'm saying it's part of saying I want you to give them 2.5 mg pills.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I understand that, and I'm—

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
And not the dose, that's not the dose. That's the strength of pill that I want to give them.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I understand and I have no problem with pill size being part of the prescription. I'm just saying do we want to pre-coordinate that as a national standard for the way we manage drug information?

Betsy Humphreys – National Library of Medicine – Deputy Director
My question—and you all know much more about this than I do—if we're going to break this apart and therefore, I mean are we all set there in terms of the actual formats of the messages and stuff that are used for this? I mean are they expecting that to be a—is it parsed into different parts?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Well, Linda does the NScript standard—I don't have it memorized, does it allow for a data element or component that would be pill size?

Lynn Gilbertson – NCPDP – Vice President of Standards Development
In parts, yes.

Clem McDonald – Regenstrief – Director & Research Scientist
I'm fairly sure the HL-7 message does; I'm not as familiar with the NCPDP message.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
So I guess that's a yes, Betsy.

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't know. I guess my feeling about all of this is that if—well this will be an interesting discussion. I mean my view was that in effect, RxNorm had been developed in the way it was based on discussions and stuff coming out of HL-7 group around what would be required in this area, so—

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I think its major feature, I mean if you want to think of it from what are its advantages, is that it has a more direct correspondence to NDC codes. That's something to bear in mind and weigh carefully, but obviously I'm thinking of it from the perspective of secondary use and decision support and other kinds of areas where I think there's significant advantage to have data elements that are clearly defined so that you can compute a dose, either on pill size and number, or on dose itself. That you can understand what the agent is and deal with that as a single entity and not have a whole family of pill size variations sort of muddying the waters when trying to use these data in secondary context.

Betsy Humphreys – National Library of Medicine – Deputy Director
My own view of it is that you can—I mean I believe there are direct connections and approaches in terms of the RxNorm graph to abstract away from that level of detail for the purposes for which that level of detail is not needed.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I actually do think, Chris, that there are use cases where I want that pre-coordinated dose, pre-coordinated strength in the pill. It makes the user interface easier. If you separate it out, then you've got to have another source that tells you what pill sizes are available for that medication. Otherwise, they could put in pill sizes that don't exist. I actually do want it pre-coordinated and you keep in a knowledge base that 2.5 Coumadin pill is a 2.5 mg strength so that you have that and you can actually make all the calculations that you said, but yes, I actually want the pre-coordinated strength concept.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Okay. I don't mean to belabor it. I was just throwing it out as a logical thing to consider and I'm not hearing a lot of uptake, so, so be it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well I think that was a very useful discussion but it still, in my mind, comes back to the timing issue.

Betsy Humphreys – National Library of Medicine – Deputy Director
The issue, I guess, is whether whatever people are using now—Clem is commenting that I'm looking at existing messages that are going around. We may have a total lack of standardization. So is your issue that you don't think we can move to a standard—that 2013 may be too soon for a standard, or that 2013 may be too soon for a single standard?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I'm thinking that for a single standard, I mean I'm just thinking that just getting RxNorm fully established in the drug compendia and propagate it to the applications for us is going to take a couple years.

Clem McDonald – Regenstrief – Director & Research Scientist
Do you know that? I mean do you know that it's not in the drug compendia now?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, not for us.

Clem McDonald – Regenstrief – Director & Research Scientist
So you're not using one of the big ones?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I mean to get it fully established. We do use First DataBank.

Clem McDonald – Regenstrief – Director & Research Scientist

I believe they have it. That's an aside.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
There is a representative from at least one of the drug database companies on the phone.

Clem McDonald – Regenstrief – Director & Research Scientist
Can we confirm that?

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Tom or anyone else, are you available to speak in? We may have to go off—

Clem McDonald – Regenstrief – Director & Research Scientist
Well the other thing to think about in terms of say making the byte size smaller; there are successful communications for maybe decades, for a long time, from pharmacies to the pharmacy benefit managers. And I think they mostly use NCPDP. What I do understand but I don't have direct, hands-on knowledge, is that an awful lot of the Rx—the scripts messages are coming across and it's just names, text and/or NDC surrogates. Whether one might focus on that end of it as a place to introduce RxNorm which is from places that I don't much in place yet and if they get—and it really doesn't work great for you because of that. Because it just comes across as text. So it could be a big improvement.

Betsy Humphreys – National Library of Medicine – Deputy Director
So is the action item—I mean is an action items where we could follow up with the—I mean I guess Jamie, if in fact … or your source comes with this connection—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Oh no, so I'm saying that we could handle it within that timeframe but it's not an insignificant amount of work.

Betsy Humphreys – National Library of Medicine – Deputy Director
The other issue would be whether there would be tools or things that would help people go from where they are to where they want to be with this. I mean my assumption is if you're using anybody's drug knowledge base then what you want is for them to be able to help you do this, right?

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Correct.

Betsy Humphreys – National Library of Medicine – Deputy Director
What percentage of the universe is that and what does the rest of the universe look like? I mean are there a lot of practices, for example, that would have EHRs where they wouldn't be using these systems at all?

M
I think that's true, Betsy. I mean I don't know the numbers. I think the numbers are actually probably known and maybe we should just do some investigation to find that out. But I—

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes, because then the question would be—well, okay. What would have to be done in that space and is it hard or easy to do it?

M
Yes.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Tom Bizzaro is on the line but I don't know if he has access to speak.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Actually this is Tom. I've just been given access.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
I don't know if there's any drug knowledge base on the phone.

Betsy Humphreys – National Library of Medicine – Deputy Director
So Tom, please enlighten us.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations
Okay, thanks. For those of you who don't know I'm Tom Bizzaro. I am a pharmacist and Vice President of Health Policy & Industry Relations for First DataBank. As to the availability or RxNorm codes, to my knowledge all of the major compendia have a cross reference from their proprietary identifiers of some sort to RxNorm codes. Those are available in the marketplace. The comments that were made as to their usability in a live, productive system, I wouldn't say that—there are a few out there. We've heard of a couple of them but it is not commonly used because I think the industry is waiting for more direction from groups like this and ONC as to what the requirements are going to be. I do believe that over the course of the last year or so there has been a lot more familiarity with RxNorm by the vendors and the IT systems in both pharmacy, e-prescribing, and EHR vendors and that's a good thing.

With RxNorm, what we're looking at in e-prescribing for example, is the construction of RxNorm lends its use to e-prescribing and dispensing. Knowing that you would still have to have a proprietary database in place to do all the other things that were mentioned on this call already, for things like clinical decision support and pricing and getting down to an NDC level. What I'm saying from, at least from my point of view, that RxNorm in my experience as I look at it for the uses that I've just described, does allow itself that use. Knowing that there are some limitations, the comprehensiveness, the confined scope of RxNorm, but I think those things are all things that can be dealt with. RxNorm does seem to have become commonly understood in the industry as something that we could use going forward as a national vocabulary.

I did have one more comment and then I will stop and see if you want more comment. One of the things I think that is necessary is that I think the industry is looking for direction as to what part of RxNorm are we going to be talking about as part of the subsets? Are we talking about that Semantic Clinical Drug? Are we talking about the Semantic Brand Drug? Those types of things and that type of specificity as to what of RxNorm is going to be required, whether it's in certification as a national standard, would also be helpful.

Clem McDonald – Regenstrief – Director & Research Scientist
Well I think you've encouraged me to say that we got to get off the dime because everybody is waiting for everybody.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations
It's a little bit different from FDB's point of view because as a vendor of a knowledge base is, it actually is probably a lot more—not probably, as I think it is a lot more work for those system vendors and developers to make use of the content that we can give them cross reference to our data. It's certainly much more complicated for them.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well I think the question comes back again to timing and feasibility of RxNorm for prescriptions. I think, regardless or perhaps it's not true, but I think regardless of which subsets we're talking about for stage two of meaningful use in terms of timing. I'd love to hear more comments on the stage two versus stage three timing question.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
I obviously represent a provider who will be greatly inconvenienced by what I'm about to say but I sort of agree with Clem in that it may be time to do something. Putting a stake in the ground on something that is as obvious as RxNorm I don't think there's a lot of controversy about whether it's the right standard, my

whining about RxTerms notwithstanding and it's something that is being accommodated and looked at by obviously the major information vendors and I might add EMR vendors as well. I think of the grand scale of things that we might contemplate in phase three, RxNorm is sort of low-hanging fruit in a relative sense and my preference would be to consider it in the context of the 2013 and reserve for more ambitious and arguably challenging control vocabulary use in 2015.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Chris, I think the other thing to think about—and I agree completely with what you sort of articulated. We will learn an awful lot in putting a stake in the ground and really trying to move forward. I think there are ways that we can try to assist the vendors and the providers and the hospitals to get there easier, and I think having a standard identified and a certification criteria that helps provide incrementalism, if you will, I think it's helpful. We hear sort of two things often times from the industry. The first thing we hear is, "We can't possibly ever do that. It's going to just take us too much time." Then the other thing we hear is, "If you guys would just make a decision we could start planning." So there is some clarity, I think, in sending a message that says this is what we want to do and this is where we're going to go and putting that down payment in place. Being cognizant of the burden that that causes and then working to try to mitigate that burden through tools and resources or other things that might make the job easier if people are moving in that direction.

Betsy Humphreys – National Library of Medicine – Deputy Director
To add to that I heard Tom's point and we have had the same question from others about exactly which piece or which category of things within RxNorm is to be specified as the standard. There is a good answer to that and we are actually expanding upon and changing documentation to make that clearer, but we'll provide that information back to the group. I think it probably should be included in a proposed specification of it as a standard.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Another aspect of input information might be from the actual testing that is going on for meaningful use. The number of entities that are testing and the ones that are using, what we would expect, hopefully, of using RxNorm to actually do those tests. So that might provide you some data as well.

Clem McDonald – Regenstrief – Director & Research Scientist
Well I get back to getting off the dime. The industry, I think, would probably like something more—realistically, I mean they could actually do a lot more if things were more regular. I've talked to people who are—the process now, if a practice or a hospital wants to help physicians pick drugs it's about impossible. There's something like 2,000 or 3,000 formularies. They're all made up with these NDCs, which don't necessarily represent the real drug but they're sort of these surrogate NDCs and it's almost impossible. This could've been a lot simpler and doable for a lot places if there was one code that was being used to identify the thing that was prescribed. I mean at least in transit. I think what one could decide how to narrow what the scope is I would suggest it's the brand and the generic names of the clinical drug constrained to those that are currently prescribed. And there's ways to define that.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I'm in favor of going forward with the same trepidation that Chris has. My institution may complain at me when they know that I think it's time to go forward as well. It may be a little aggressive and I guess there will be opportunity for the public to comment on whether they think it's aggressive but I think it's time to sort of put a stake in the ground and say this is where we're going and let's try and get there by this date.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I want to propose a different form of moving ahead. I think first we ought to put a stake in the ground and say RxNorm's going to be required for MU3. Then we ought to review small vendors' use of third party databases and publish our analysis of that use and its implications for what we're doing by date certain, six months from now, three months from now. I think we ought to review the experience of current users of RxNorm in detail and publish that by date certain, along with the implications from manufacturers and implementers. I think the third thing we ought to do to get off the dime without shooting the horse is to put the ability of EHRs to use RxNorm in third party databases and to certification by 2012-13.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Doug, can we do that?

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Yes, I think the proposal—if I can play it back and Jim correct me if I don't get it right, but to boil it down is that the use of RxNorm for external prescriptions would be required for EHR certification in time for stage two, but would be measured for applicants for the incentives for implementers for stage three. That starting immediately we would go out and measure and analyze and report on the use of RxNorm in the wild.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Then the third was the results are raised, that we need to understand better what the small manufacturers that most of the small practices are using—what their readiness, or whether they will be … or not.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Sure. It's an interesting question. I don't think anyone has asked about sort of including certification criteria into stage two, meaningful use, but then giving people—doing the recording of that, if you will, in stage three. That's a question that I can raise with Josh and just sort of see if that's something that the HIT Policy Committee has considered.

I think kind of the broader context though is the discussion about sort of getting a stake in the ground and trying to move forward. And at the same time figuring out a way to reduce the impact or the burden, if you will, and make it easier for people to reach the meaningful use stage two criteria, I think that's an important conversation to have. I think we probably should consider lots of different ways to do that. One in the way that you're sort of suggesting is that we would delay reporting. There are other ways to think about that too with regard to certification criteria or other things but I like the notion of sort of directionally putting a stake in the ground and then really having some discussions about the feasibility, the timing, ways to create an incremental step that gets us moving in the right direction. I think those are all really important things to think about.

So I don't have the answer. I think I would have to really talk with Josh about that first because what you're really saying is that there are standards, certification criteria, and then sort of the meaningful use objectives that people would attest to or that would be able to demonstrate. All three of those pieces have to work together. We just have to make sure that we've got the right lever to achieve the goals that we've got.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Part of what I'm proposing is that we take some of the onus on us as well as putting a good bit of it on manufacturers and implementers.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well the thing that I would say is, I do think that it would be important to have a better idea of how the practice systems are handling or proposing to handle e-prescribing now. And whether there is or isn't an obvious strategy that would make it hard or easy for them to, in essence, put RxNorm in the transmission message.

M
At the very coarsest level we don't know—if we went asked Stan … would say, "That's one of the easiest things we ever did. We should have done it five years ago." Or they would say something else.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability

I think we have some time over the summer to get some of that information and so kind of recognizing that and trying to figure out where all those pieces fit. I think we've got a little bit of time to ask some of those questions and I guess the question for the committee is if you were to do those sorts of things, do you need to know them over the summer? Is there a hearing that needs to be held? Is there a survey or blog post that needs to go out? How would you gather that information and in what timeframe to be useful?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I would hire a really good interview company to go out and do intensive, large scale interviewing of both of those communities and produce a genuine publishable review of those two questions and if that could be done by September—I think it's possible that it could be. That would be pushing it pretty hard.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Recognize that not only do you need the piece of the EHR vendor community whether or not they do or do not use drug knowledge base as their support for the drug fields. But you also have to prepare the pharmacies for accepting the RxNorm codes instead of what is being done today.

Clem McDonald – Regenstrief – Director & Research Scientist
That's why I like to emphasize the e-prescribing side because I don't think they're getting any codes now—and that's another thing to check on. I don't see how they can lose. I think they're mostly typing them in again.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
The practice today, if you are using a drug knowledge base or a drug system of some type, the electronic new prescription contains a mandatory description of what is being requested for prescribing. So that text as you refer to it, that is mandatory. In practice, there is an optional, often-used representative NDC until we were sure if the RxNorm code would work in that case.

Clem McDonald – Regenstrief – Director & Research Scientist
But what I understand from the troops in the field is that really it's mostly coming in as text. The representative NDC is almost goofy. I mean it almost makes you giggle when you think about its purpose and when are we ever going to—that's a lousy situation. If we study this much more, we'll never find out. People won't have time to prepare if we make this … six months.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Right, and the industry is actively preparing for the use of the RxNorm. Now what would be of interest, obviously if you wanted to know, is their timeframes but this is a very active activity for the pharmacies as well as the prescribers.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
I want to just break in here because I think we're at the hour, right now, and I'm going to have to get off the call as well. I think this is sort of exactly the kind of conversation that we need to be having to help inform the HIT Standards Committee in terms of recommendations that they forward to ONC and to the secretary so if you want to continue the conversation, that's great. I'm just going to have to get off and I'll catch up with—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay, so Doug, can I just ask it—will you please take back that question of whether we can have perhaps certification in stage two and measurement in stage three as one potential option for laying out a path to implementation?

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Sure. So I'll take that in and Judy and I and Josh will sort of get together and see if that's an option. I'd also challenge to think about other ways in which we can provide clear directional focus for the providers and for the industry and at the same time create an incremental approach to get there. We should have a couple of options to consider if we run stuff with one approach.

Clem McDonald – Regenstrief – Director & Research Scientist
And before we get too far along I just want to understand—are we going to talk at all about the document that's dated August 20, 2009?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well I mean I think that was the basis for this conversation because that's where the recommendation for RxNorm was laid out as a previous recommendation from the HIT Standards Committee.

Clem McDonald – Regenstrief – Director & Research Scientist
There are some things that are confusing that and maybe contradictory in it, but—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. So I didn't think we were going to go through that in more detail—

Clem McDonald – Regenstrief – Director & Research Scientist
Well you've got something on the table now so I don't want to distract from it. I just wanted to know if we come back to some of those other ones.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
We can. I think that's going to have to happen in other calls. Judy, we have other calls scheduled—I'm not sure what the exact schedule is though.

Judy Sparrow – Office of the National Coordinator – Executive Director
While I look for it, continue and I'll let you know at the end of the call.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well I think that was a very useful discussion. Jim, I like your suggestion. I'll ask if this is really a consensus or not, but I think the sense of the group is that we do want to put a stake in the ground. We want to have a reasonable path to implementation in a timeframe that's achievable and the stake in the ground we think should start with stage two, at least with certification of EHR systems. Does anybody disagree with that as the—or the outcome from this discussion at this point?

Betsy Humphreys – National Library of Medicine – Deputy Director
Well I don't … that we should get more information and that it might be—we might discover there are enough signs pointing that we could, in fact, recommend that RxTerms be at least proposed for phase two when the notice of proposed rulemaking goes out for meaningful use.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right.

Clem McDonald – Regenstrief – Director & Research Scientist
I think from what I heard, it might be useful to define the boundaries, even in terms of what exact subsets—the question about the brand names versus the generic names, and also maybe the messages for which it's got to be in first. It might be more disruptive to argue it for everything in all pharmacy messages versus for the script standards, which is really where the rubber hits the road, clinically.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. I do think that we're talking about the—and correct me anybody of this is off base but I think we are talking about those prescriptions that are already being measured, using the … through certification and the meaningful use program, using the script standard.

Clem McDonald – Regenstrief – Director & Research Scientist
Oh, okay. Good.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Is it an open question whether we might want to expand that to some of the inpatient—I guess what we'd think of as inpatient orders that would use the HL-7 …—?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I mean I think that is an open question, certainly in my mind. And one of the other teams that's going to be formed over the summer for the ONC summer camp will focus on discharge medication orders. As I think that may be another venue to bring up that question, but what's your thought on that, Stan?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Well it's a natural progression. I think like anything else it's a question of schedule and--but I think that would be supportive of that.

Clem McDonald – Regenstrief – Director & Research Scientist
I would too.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Oh, okay. So maybe we can talk a little bit about what components of RxNorm in terms of the, for example, generic drug name, the branded drug name, packaging for generic or branded. What is it that we're talking about recommending here?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
That discussion would be helped a bunch if we had that diagram with all of them. I don't know them all by heart.

Judy Sparrow – Office of the National Coordinator – Executive Director
Let me just see if I can find you a pointer to the diagram.

Clem McDonald – Regenstrief – Director & Research Scientist
Well I think the generic clinical drug name and the brand drug name are both important because you can't, people will pick—they can't write the prescription, I mean you have to know both. You have to have them both.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Right, I think we're going to need ingredients, aren't we?

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations
Yes, I think two things that we've kind of seen already that the industry is expecting to use—and this is in e-prescribing and then on the dispensing end—is the Semantic Clinical Drug and the Semantic Brand Drug. Because we know that the physician will want, at some time, to make a distinction that he wants a brand and he wants that brand dispensed as a DAW prescription. So those two things I think are very much necessary.

The other discussion that we've been having is when you need less specific information—and this may not be in e-prescribing, but for example for an allergen where a patient doesn't know the strength or the dosage form of the product, would it be appropriate then for something like a brand name code from RxNorm to be used? The third thing with ingredients is one of the things that we've talked about with ingredients is the description of an allergen for a patient. What ingredients from RxNorm, the ingredient … makes sense as an allergen but for the dispensing process in e-prescribing, I think that certainly the Semantic Clinical Drug and the Semantic Brand Drug are most commonly being reviewed and evaluated.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
We had a task group of the industry look at the e-prescribing standards that are used—the script standard and the formulary benefit for example. The recommendation that was approved was the Semantic Clinical Drugs, Semantic Branded Drug, Generic Package, and Branded Package—those were the four qualifiers that were added into the e-prescribing script and formulary benefit exchanges.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Just to be perfectly clear I think in what we specify we want to specify that the set of things that we're saying are for prescriptions and a different set of things that overlapping that are the allowed concepts for the allergens.

Clem McDonald – Regenstrief – Director & Research Scientist
Can I clarify? Are you talking about allergens that are dispensed and stuck under the skin or are you talking about allergies?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
No, allergies—the chemicals that cause allergies. In my limited—the things that are allowed in prescribing and orders and the things that are allowed in an allergy record, which are slightly different subsets … or supersets as the case may be. So not lump it together and say we're going to use RxNorm and say we're going to use these parts and not say which parts go with which context.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Right. In terms of directionality, we don't need ingredients—is the need to have ingredients to do interaction checking separate from this?

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations
I can speak to that. The way that the database is—and I can speak in general terms, not just to First DataBank. The way the database is well-cross referenced from a vocabulary of RxNorm to their own proprietary vocabularies will allow for the typical type of clinical screen that we do now, whether it's dose checking or allergy checking or drug interaction checking, allergy checking, all those things. Because those cross references to those for proprietary identifiers will still allow all that clinical screening. Now this is kind of a personal hope, at some point in time, I would hope that First DataBank would be able to directly code against those nonproprietary identifiers and then that way there's no chance of losing of the context for which the drug was prescribed, or is being used in a clinical setting. That's way down the road.

Clem McDonald – Regenstrief – Director & Research Scientist
I'd like to—actually I do a little bit for ingredients not for that reason, but because there are some people using RxTerms, which devolves directly into RxNorm but it's got some differences in it. It also comes out in NLM, and the code is not different but the ingredient is needed to make that all work. That may not be a justifiable reason.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I didn't understand what you meant, Clem.

Clem McDonald – Regenstrief – Director & Research Scientist
Well that the ingredients would be part of the package of RxNorm that's supported.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Well I think I understand but I'm not sure that's actually a good thing to say. That's a very reasonable way to approach it but I mean really what we're saying is those ingredients—I don't think you're proposing those ingredients of themselves would be orderable.

Clem McDonald – Regenstrief – Director & Research Scientist
No.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
And, in fact—yes, so that seems like that's out of scope to me. If people want to use those ingredients and use them in the way that you described that's … approach but another approach is that those ingredients are known in the drug knowledge bases and you do it that way. If we want to enable exchange of knowledge about ingredients and allergies, that's a different kind of message in a different scope, which I would be very much in favor of but I just think it's a different thing.

Clem McDonald – Regenstrief – Director & Research Scientist
I agree it's different. There are two or three groups that are using RxTerms—and well I guess, never mind. They can still get them.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. So I think we're generally all supportive, then, of essentially saying that the same four things that were specified for use in the script standard, are what we would recommend, is that right?

M
Agree.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

W
That seems reasonable. Could you repeat what those are? Could Lynn repeat what those are?

Lynn Gilbertson – NCPDP – Vice President of Standards Development
I'm sorry, what was the question again?

W
The four things—parts of RxNorm.

Lynn Gilbertson – NCPDP – Vice President of Standards Development
Oh, okay: the Semantic Clinical Drug, the Semantic Branded Drug, the Generic Package, and the Branded Package for prescribing.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Jamie, do we want to specify what we would do in addition to that for specifying allergies?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well as you said, Stan, that's a separate issue and I think here we're talking about drug orders.

Betsy Humphreys – National Library of Medicine – Deputy Director
The allergy issue comes up on the chart but before the one we're looking at though, medication allergy, on page three of the previous chart.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
It's in the bottom of the same box that we're looking at.

Betsy Humphreys – National Library of Medicine – Deputy Director
Oh is it also there?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
It's also there. That's why I mentioned it. So we're just saying that for everything that we've said so far about certification and meaningful use three is really just talking about the use of drug codes in the prescriptions and not in allergies.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well now if you wanted to ... talk about exchanging information about allergies and ingredients in separate messages, then I think that's a separate discussion.

Betsy Humphreys – National Library of Medicine – Deputy Director
So is it one we want to have now or at another time?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I would say at another time because the one other thing I wanted to bring up for this call, which Doug Fridsma brought up earlier, is the idea of subsets and what would be required in certification. I mean, I think the last thing we want to do is to bake into regulation the next Vioxx, if you will. And yet how do you avoid that, if you're going to have to specify?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Jamie, just a question on that. In prior rules, there was—is there a way to talk about things like the most recent version of some whatever that standard is with the minimum being whichever one we're describing? I don't know if that was clear, but does somebody understand what I said?

M
No.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So for example, what we tried to do previously for lab orders was to say it was the 95% most frequently ordered routine lab tests as reported in HEDIS. I think that the guidance that we've gotten from ONC at that time is that no they want an enumerated list of codes to go into the … that is specifically testable.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
But I think the problem with that was you had to say the minimum list is what exists at this time but you'd have to say—what we'd have to do to avoid the next Vioxx is to say to go with the current one but I know that's a problem for the rule.

Clem McDonald – Regenstrief – Director & Research Scientist
So the rules can't refer to a source?

Lynn Gilbertson – NCPDP – Vice President of Standards Development
It has to refer to a specific source.

Clem McDonald – Regenstrief – Director & Research Scientist
But I thought I heard there was one where you could say now—in fact they did in the last one, but it would accommodate—you were allowed to use the next version.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, and I think their wording was something like "at the minimum you must use this version."

Clem McDonald – Regenstrief – Director & Research Scientist
That's how I remember it.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
That's what I was trying to say before, I'm sorry.

Clem McDonald – Regenstrief – Director & Research Scientist
NDC has stuff in it you don't need. I don't want to bring that up again, but would you say the current NDC you must support all of it?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
No, I think what we're talking about now is what's the subset that's going to be tested for certification?

Clem McDonald – Regenstrief – Director & Research Scientist
Oh, okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So, then what are—

Clem McDonald – Regenstrief – Director & Research Scientist
I think a subset could be specified and listed and given as long as—because these things, you get new drugs come out. So you wouldn't want to forbid going forward if people wanted. You like to encourage them to use the next one as well; like they did in the last round.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
We may need to specify a version or this minimum version and the next version but I think here I would take a different path than we took when we were talking about some of the lab mapping. Mapping here is not—well it's already done essentially. So I think you just say you certify against all of the concepts in those four subclasses and be done with it.

Clem McDonald – Regenstrief – Director & Research Scientist
Well Stan, there's drugs in it—this is the only …, there's drugs in there, I think they still are—holler if I'm wrong, because it's an archival file like U80 Insulin, which isn't prescribed for ten years.

Betsy Humphreys – National Library of Medicine – Deputy Director
We could, in fact—

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Could we get those out of there?

Betsy Humphreys – National Library of Medicine – Deputy Director
I mean I think we could exclude those that are known to be—

Clem McDonald – Regenstrief – Director & Research Scientist
Yes, yes. We could easily.

Betsy Humphreys – National Library of Medicine – Deputy Director
Don't know precisely at any given moment because between now and then another one could be removed from the market, but we could certainly take off the ones we know are.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I would be in favor of that.

Betsy Humphreys – National Library of Medicine – Deputy Director
Okay well based on this conversation, I'm going to confer with our RxNorm experts and see if … come up with a suggested formulation for this and tell everybody how big it is. How about that?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I like that.

Betsy Humphreys – National Library of Medicine – Deputy Director
Then we'll at least know what we're saying, in terms of hundreds or thousands or whatever.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
When we remove those, they'll still be available for managing historical records of patients and so forth?

Betsy Humphreys – National Library of Medicine – Deputy Director
Well obviously Rx itself will not exclude them; it will be a question of are we proposing a subset that could be used in testing, that would be things that would be currently prescribed.

Lynn Gilbertson – NCPDP – Vice President of Standards Development

As long as it was clear that this was just a subset for testing and is not the only subset allowed for production.

Betsy Humphreys – National Library of Medicine – Deputy Director
You have to do that. I mean—and of course, obviously the fact that people were once prescribed Vioxx is still potentially a relevant piece of information.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Right and in a production system, we never remove those things we just say if I order something that's off the market it says, "This is off the market." Otherwise the user thinks they misspelled it or something. That's the kind of thing I'm talking about.

Betsy Humphreys – National Library of Medicine – Deputy Director Yes, well we're not intending to take any of them out RxNorm but if we're trying to—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
No, no, it's fine. I just was confirming. I was sure you had already thought of that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well I thought this was great progress today. Thank you all very much. We'll certainly come back to continue this. I think we will have a separate discussion on allergies and allergens but I think the next two priority items that ONC's asked us to work on as a task force are vocabulary recommendations for routine clinical lab results and for a problem list. So we'll have an opportunity to get to those as well.

Clem McDonald – Regenstrief – Director & Research Scientist
I'd just like to ask if at some point if we could have a little discussion of some of the things on this 209—unless that's never going to happen. I mean until we discuss it as a separate challenge.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Clem, could you write us a real short memo and just outline those things. I think it would be worth—I'm always disposed to try to make sure we got that kind of thing straight, and if you could that I think that could sort of get us well into the discussion.

Clem McDonald – Regenstrief – Director & Research Scientist
I will.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
But is correcting the old document what we need to do, or do we just need to make new documentation that's correct?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes I think we're using this as a reference to figure out what needs to change and how we go forward.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes I think well at least not a version control it might be really a new document, but it—

Clem McDonald – Regenstrief – Director & Research Scientist
That's not important just that the concepts that are there to try to straighten them out a little bit in whatever form it ends up in.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Can I just make sure everybody knows something about the ecosystem we're talking about putting this in? We are ready to send discharge medication prescriptions electronically and we concluded that we can't safely because essentially no pharmacy—and this includes big chains—in their software system can receive cancellation orders. So I'm not sure what it means to this group but I think there may be wrinkles in the receiving of this stuff that we want to make sure we understand.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Patricia Greim – VA – Health System Specialist: Terminology
Jamie and Betsy, I did join late but I'm glad to here for this important discussion. Thank you.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Good, thank you Patti.

Betsy Humphreys – National Library of Medicine – Deputy Director
Do we have other people, other than Tom, who has contributed a great deal to this discussion—other members of the public who have comments?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes, let's turn to public comments at this point in time. I think that we're wrapping up the call.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, thank you Jamie. Operator, can you see if anybody wishes to make a public comment? Jamie, while we're waiting the next Vocabulary Task Force call is May 10, 2 to 3:30 and then we also have one scheduled for June 1, 1 to 2:30; although I think May 10th is a problem for you, correct?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I'll have to check that.

Judy Sparrow – Office of the National Coordinator – Executive Director
Anyway, that's what I currently have on the books. If it changes, I will let everybody know.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay, thank you.

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Thank you. That was a good discussion.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay, that was great. Thanks everybody and I'll see you next time.